State of Idaho Emergency Medical Services Bureau
Provider Application Form

Level Applied For: ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT ☐ Paramedic

Type: ☐ **Initial ($35.00 fee** for Advanced EMT and Paramedic) ☐ **Recertification ($25.00 fee** for Advanced EMT and Paramedic)

☐ Direct Bill my Agency - Agency Name _____

☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

Applicant Information:

Social Security # ___ - ___ - ___ Date of Birth ___ / ___ / ___ Drivers License # _____ DL State _____

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____ Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

Signature Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification:

	Volunteer	*Career*
	☐ True	☐ Full Time
	☐ Compensated	☐ Part Time

Have you ever applied for, been denied or received an EMS certification or licensure in any other state? Yes ☐ No ☐

If yes, complete an *Idaho EMS Certification Verification Request* form for each state you applied for or ever held an EMS certification / licensure.

Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed

For Bureau Use Only

Received in RO

Received in C&L

Cert. Fee Rcvd Date _____

☐ Cash – Receipt # _____

☐ Check # _____

☐ M.O. # _____

☐ DB - Agency _____

Process Date _____

First Responder and Basic

Test Date	Expiration
10/05-03/06	3/31/2009
04/06-09/06	9/30/3009
10/06-03/07	3/31/2010
04/07-09/07	9/30/2010
10/07-03/08	3/31/2011
04/08-09/08	9/30/2011
10/08-03/09	3/31/2012
04/09-09/09	9/30/2012
10/09-03/10	3/31/2013
04/10-09/10	9/30/2013
10/10-03/11	3/31/2014

Advanced and Paramedic

Test Date	Expiration
10/06-03/07	3/31/2009
04/07-09/07	9/30/2009
10/07-03/08	3/31/2010
04/08-09/08	9/30/2010
10/08-03/09	3/31/2011
04/09-09/09	9/30/2011
10/09-03/10	3/31/2012
04/10-09/10	9/30/2012
10/10-03/11	3/31/2013
04/11-09/11	9/30/2013
10/11-03/12	3/31/2014

EMT-AMBULANCE RATING REQUEST

Applicant Name:_____ EMS Provider Number:_____

I hereby verify the applicant named on this form has completed twenty-five (25) patient contacts under the supervision of a preceptor certified at the EMT-Basic level with an Ambulance rating or higher certification, between the dates of _____ and _____

Patient contacts are defined as those encounters consisting of a complete patient assessment or being the primary medical care provider for the duration of on-scene intervention or transport.

Signature of Agency Medical Director or Designee

_____

Agency Name

_____

_____

Printed Name of Agency Medical Director or Designee